DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 9/12/10

PRINTED: 08/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445483	A. BUILDING _____ B. WING _____	07/29/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPALACHIAN CHRISTIAN VILLAGE	2012 SHERWOOD DRIVE JOHNSON CITY, TN 37601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure privacy during medication administration for one resident (#11) of twenty-five residents reviewed. The findings included:	F 164	**F 164 483.10(e), 483.75(l)(4)** **Personal Privacy/Confidentiality of Records** All licensed nursing staff were inserviced regarding procedure for administration of medications, with emphasis that medications are not to be administered in the dining room. Licensed nurses were instructed to ensure privacy during medication administration. Medication pass was observed on 7/28/10 with all nurses assigned medication administration that day to ensure no residents were given their medications in the dining room and that proper procedure was followed regarding privacy. Medication administration will be randomly observed weekly by ADON. In-services will be conducted at least annually and with new hire orientation of licensed nurses, to emphasize observation of privacy and correct procedures for administration of medications. The results of the weekly observation of the medication passes will be documented and reported at the Quality Assurance Committee meetings, at least quarterly.	8/9/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda Osborne NHA | TITLE: Administrator | (X6) DATE: 8/9/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 Observation in the upstairs dining room on July 28, 2010, at 8:23 a.m., revealed resident #11 sitting in the dining room within view of other residents and visitors. Continued observation revealed Licensed Practical Nurse (LPN) #2 attempted to administer medications to the resident three times while the resident pushed the LPN's hand away. Interview with LPN #1 on July 28, 2010, at 8:26 a.m., at the upstairs nursing desk, revealed medications are normally given in the dining room. Interview with the Director of Nursing (DON) on July 28,2010, at 8:33 a.m., confirmed the facility failed to ensure privacy by attempting a medication administration in the dining room.	F 164	**F 241 483.15(a) Dignity and Respect of Individuality** This CNA was in-serviced/re-instructed regarding the privacy and dignity of residents on 7/28/10, just after this incident. Documentation has been placed in her employee file to support this instruction along with notations of expectations of conduct and re-emphasis on Residents Rights.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to promote care that maintained or enhanced dignity for one resident (#19) of twenty-five residents reviewed. The findings included: Resident #19 was admitted to the facility on June 5, 2003, with diagnoses including Malnutrition,	F 241	All Certified Nursing Assistants were in-serviced on privacy and dignity, with special emphasis on Residents Rights, completed 7/31/10 Supervisors and Charge Nurses will monitor CNAs each shift, to ensure this deficit practice does not recur. Random rounds will be made by ADON to observe CNAs daily to ensure proper procedures and Residents Rights are consistently carried out. ADON will report to DON and documentation maintained with reporting to QA committee regarding results of daily rounds and compliance with procedures and Resident Rights. 7/31/10	7/31/10

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F 241	Continued From page 2 Pneumonia, Traumatic Brain Injury, and Depression. Observation during medication administration in the resident's room on July 28, 2010, at 11:28 a.m., revealed Licensed Practical Nurse (LPN) #2 completing a medication administration. Continued observation revealed a Certified Nursing Assistant (CNA) #2 entered the resident's room, addressed LPN #2, failed to address the resident, and stated "Is he/she wet." Interview with CNA #2 outside the resident's room on July 28, 2010, at 3:33 p.m., confirmed that dignity was not maintained for the resident. Interview with the Director of Nursing (DON), in the DON's office, on July 29, 2010, at 4:20 p.m., confirmed the facility failed to maintain or enhance dignity for resident #19.	F 241		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide medically-related social services for one resident (#16) of twenty-five residents reviewed. The findings included:	F 250	**F 250: 483.15(g)(1)** **Provision of Medically Related Social Service** Resident # 16 was reassessed re' behaviors and mood. She continues to be at risk for throwing dishes. Hard plastic plates and bowls are now provided to eat from. Contacted POA to again request permission to have resident evaluated by psychological services for behavioral outbursts. POA still refusing this referral. Social Service personnel will visit resident to allow for 'venting' and voicing of concerns and/or requests. Social Services will attempt visits at meal time to help reinforce instruction on risks in throwing dishes. Will attempt to obtain information from resident as to why she is throwing dishes. Will work with nursing and dining staff to help determine if resident needs further assistance in eating. Spoke with nursing and dining staff to re-affirm that Social Services be informed of any changes related to behaviors, so that these may be addressed and plan of care put into place.	Cont...

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F 250	Continued From page 3 Resident #16 was admitted to the facility on September 9, 2009, with diagnoses including Altered Mental Status, Adult Failure to Thrive, and Dementia. Medical record review of the resident's Care Plan dated May 20, 2010, and updated on July 28, 2010, revealed, "...Res (resident) has episodes of agitation resulting in throwing plates and dishes...interventions...provide plastic plate d/t (due to) behavior issues (resident throwing plate) for all meals...provide plastic or plates that will resist breaking or cause injury..." Medical record review of the facility's admission documentation dated September 9, 2009, revealed the resident's Power-of-Attorney declined psychiatric services for the resident. Medical record review of the Social Progress Notes dated November 12, 2009, December 11, 2009, and May 6, 2010, revealed no mood or behavioral issues or episodes of throwing dishes. Observation on July 27, 2010, at 12:30 p.m., in the resident's room, revealed the resident eating lunch from disposable ware (styrofoam plate). Interview with the Social Services Coordinator on July 28, 2010, at 4:15 p.m., at the Nurse's Station on the Ground Floor, confirmed the Social Services Coordinator was unaware of the resident throwing dishes until the morning of July 28, 2010, when Care Plan Nurse #1 informed the Social Services Coordinator. Continued interview with the Social Services Coordinator confirmed the resident had been eating from disposable ware since October 29, 2009, due to throwing dishes during meals. Continued interview with	F 250	Each resident's mood and behaviors will be assessed and the chart reviewed, as well as conducting staff interviews to determine if interventions or further assessment is needed re' mood and/or behaviors, at time of MDS assessment and as needed intermittently. Staff will be interviewed at least monthly and each resident's chart will be reviewed at least quarterly to determine if mood and/or behaviors are presenting which require further assessment and intervention. Problematic behaviors or persistently unaltered moods will be discussed at Quality Assurance meetings for group discussion re' interventions in addition to those already attempted or if standard procedural interventions are not allowed by residents and/or family members/POAs.	9/1/10

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F 250	Continued From page 4 the Social Services Coordinator confirmed the facility failed to address the resident's behavior and provide medically-related social services for the resident.	F 250		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide education on proper medication technique prior to medication administration for one resident (#23) of twenty-five residents reviewed. The findings included: Resident #23 was admitted to the facility on July 31, 2008, with diagnoses including Chronic Obstructive Pulmonary Disease and Pneumonia. Medical record review of the Minimum Data Set dated June 23, 2010, revealed the resident had no short or long term memory impairment and had been independent with cognitive skills for daily decision making. Medical record review of the Physician's Recapitulation Orders dated July 1, 2010, revealed "...Advair Disku Aer (type of inhaler)...Inhale 1(one) puff twice daily..." Observation of Licensed Practical Nurse (LPN) #2 in the resident's room on July 28, 2010, at 8:00 a.m., revealed LPN #2 administered the Advair	F 281	**F 281 483.20(k)(3)(i) Services Provided Meet Professional Standards** This LPN was inserviced/instructed on correct administration of Advair Discus Aerosol Inhaler on 7/28/10. Review of all current month medication administration records (MARs) was completed. The results of this review showed no other residents were currently prescribed the Advair Inhaler. Pharmacy was consulted for complete procedure for inhaler administration. All licensed nurses who administer medications, were in-serviced on proper administration of this inhaler. Supervisory staff will monitor/observe nurses' procedure in administering this medication during their medication administration procedural checks. This documentation will be reported to the QA committee. 8/9/10	8/9/10

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F 281	Continued From page 5 Disku Aer and failed to give instruction on medication use prior to administration. Continued observation at this time, revealed the resident took two quick puffs without holding the breath and handed the Advair back to LPN #2. Review of the facility policy for Advair administration revealed "...breathe in the dose deeply and slowly...hold the breath for at least 10 seconds, and then exhale slowly...following administration, instruct patient to rinse mouth with water to minimize dry mouth. Do not swallow water..." Interview with LPN #2 on July 28, 2010, at 8:28 a.m., at the upstairs nursing station, confirmed the medication was administered without instruction given to the resident. Interview with the Director of Nursing (DON) on July 28, 2010, at 10:30 a.m., in the DON's office, confirmed the facility failed to follow the policy for Advair administration.	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure	F 323	**F 323 483.25(h) Free of Accident Hazards/Supervision/Devices** For Resident #4, 'Pressure Sentry Alarms' were applied to this resident's bed and chair. The Care Plan was updated to reflect the current interventions used to help prevent falls and/or prevent injury. The falls investigative reports for in-house residents were reviewed to ensure new interventions were in place for each fall, which are pertinent to the residents' current status.	

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F 323	Continued From page 6 adequate supervision and assistive devices were in place to prevent falls for two residents (#4, #13) of twenty-five residents reviewed. The findings included: Resident #4 was admitted to the facility on November 26, 2007, with diagnoses including Seizure Disorder, Large Brain Arteriovenous Malformation, Type II Diabetes, Depression, and Dementia. Medical record review of the Minimum Data Set dated June 21, 2010, revealed the resident required supervision with transfers, limited assistance with walking in the room, and had experienced falls within the past 30 days and past 31-180 days. Medical record review and review of facility documentation revealed the resident had experienced a fall without injury on August 3, 2009, and a sentry alarm had been placed to alert staff of unassisted transfers. Medical record review and review of facility documentation revealed the resident had five non-injury falls between August 26, 2009, through February 13, 2010, and no new interventions were placed to prevent further falls. Medical record review and review of facility documentation revealed the resident had a fall without injury on February 19, 2010, and a seatbelt was placed for use in the wheelchair. Medical record review and review of facility documentation revealed the resident had a fall without injury on March 25, 2010, and a low bed with a mat at the bedside was placed.	F 323	Incident and Accident reports will be reviewed during the morning interdisciplinary meetings with discussion of interventions and new approaches and evaluations which can be applied to help promote safety to prevent injury. Documentation will be reported to the QA Committee during their regularly scheduled meetings, regarding occurrence of incidents and accidents, any injury incurred, treatment required, interventions applied, and residents' status, in summary form. The Medical Director will continue to review and sign the Incident and Accident Reports. 8/12/10 Cont...	

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F 323	Continued From page 7 Medical record review and review of facility documentation revealed the resident had three falls between April 9, 2010, through June 3, 2010, with the fall on May 5, 2010, resulting in a cut over the resident's right eye requiring steri-strips. Interview with the Director of Nursing and Assistant Director of Nursing/Fall Coordinator on July 29, 2010, at 10:00 a.m., in the Director of Nursing's office, confirmed the facility failed to provide supervision and assistive devices for 8 of 12 falls for this resident. Resident #13 was admitted to the facility on August 28, 2008, with diagnoses including Muscle Weakness, Fractured Hip, Dementia, and Hemiparesis. Medical record review of the Minimum Data Set dated June 5, 2010, revealed the resident had short and long term memory problems, required moderate assistance with decision making, and required extensive assistance with transfers. Medical record review revealed the resident had a history of falls. Medical record review of a Physician's Order dated December 8, 2009, revealed, "Criss Cross seat belt while up in W/C (wheelchair)..." Observation on July 27, 2010, at 1:30 p.m., revealed the resident sitting in a winged back chair, in the resident's room, with the criss cross belt around the resident's waist and the chair with the straps attached to a walker, located behind the winged back chair.	F 323	For Resident #13, the seat belt restraint ordered for use while in wheelchair, which had been applied to winged back chair and secured to walker by a family member/sitter, was removed on 7/27/10. The family, sitter and other caregivers were educated as to proper application and use of restraints and the current order in place for this resident. The family was asked not to bring in restraints from home and to speak with nursing staff to present ideas to prevent accidents and/or injury for resident prior to applying these ideas, (the family explained they had used the walker behind this new chair to secure the seat belt to, to prevent falling from chair while they were present, hoping to prevent injury). All restraint orders for current residents were reviewed and actual applications were evaluated for correct use. The staff were instructed on correct applications according to manufacturers recommendations, and to be conscious of any applications which family members may apply during their visits, and procedures to take to educate families regarding correct applications and following procedures and orders. The ADON will monitor restraint usage and application during daily rounds, reporting irregularities to DON and following thru with correcting these irregularities with reinforcement to staff to continually monitor and correctly follow restraint orders. Results of daily rounds and restraint evaluations/observations will be reported to the QA committee during their regularly scheduled meetings. 8/12/10	8/10/10

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F 323	Continued From page 8 Review of manufacturer's recommendations on July 27, 2010, revealed, "Lay the lap belt across the patient's thighs. Bring the ends of the connecting straps down at a 45-degree angle between the seat and the wheelchair sides..." Interview with Licensed Practical Nurse (#1) on July 27, 2010, at 1:40 p.m., in the resident's room, confirmed the seat belt was not applied according to manufacturer's recommendations.	F 323	**F371 483.35(i) Food Procure, Store/Prepare/Serve - Sanitary** After an internal investigation, it was found that the pre-cooked chicken wings that were observed in the Independent Living refrigerator, were put there by our baker, who was going to use them for their own personal lunch during that week. This employee was re-inserviced re' the proper storage of foods in refrigeration. The employee has been disciplined with a written notice placed in their file.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure food items for resident's consumption were labeled and dated with serving dates and cookware was cleaned and stored properly. The findings included: Observation of the kitchen area on July 27, 2010, at 7:35 a.m., of the reach in cooler, revealed two packages of pre-cooked chicken wings not dated or labeled. Continued observation at 9:50 a.m., revealed a free standing mixer covered with a	F 371	Employees will be re-trained on proper procedures for storage of pre-prepared and left-over food items, re' labeling and dating. The Dining services staff/team members, will conduct daily checks of all food storage areas to ensure all items are properly dated and labeled. Staff will report findings to the supervisor and any irregularities will be corrected immediately, and investigation will be conducted to determine which team member needs to be in-serviced and retrained. The Dining services manager will conduct periodic checks, at least weekly, to determine staff have conducted the daily checks to ensure all procedures are being followed pertaining to food storage, labeling and dating. An internal investigation revealed that the green vegetable leaf and pen observed in the mixing bowl had most likely fallen from the prep table and into the bowl sometime after the cleaning of the mixer and bowl and before the mixer cover was placed over the mixer and bowl. The current policy is for the bowl to be cleaned and sanitized before and after each use, therefore the pen and leaf would have been discovered and removed and appropriate action taken at the time of the next use. Staff have been re-inserviced re' proper sanitizing procedure and have been instructed to take care in storing equipment and food prep utensils. A complete check of all kitchen equipment has been conducted to ensure all utensils and equipment is sanitized and stored properly at this time. Staff will conduct daily checks of all food prep equipment to ensure it is properly cleaned and stored. Staff will undergo routine in-service training throughout the year re' proper cleaning and sanitization procedures.	Cont...

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F 371	Continued From page 9 clear plastic bag. Observation revealed when the plastic bag was removed a green vegatable leaf and a ball point pen was observed in the mixing bowl. Interview with the executive chef on July 27, 2010, at 9:55 a.m., confirmed the food items were not labeled or dated and the mixer was not cleansed and stored properly.	F 371	The Dining services manager will conduct checks periodically to ensure staff have maintained the facilities procedure for cleaning and sanitizing equipment and utensils.	08-09-10
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to dispose of garbage properly from the dietary department in a safe and sanitary manner to prevent the harborage and feeding of pests. The findings included: Observation, with the executive chef, on July 27, 2010, at 10:00 a.m., of the outside garbage receptacles revealed a large amount of small ants surrounding the garbage receptacles. Interview with the executive chef on July 27, 2010, at 10:05, a.m., confirmed the garbage receptacles were not maintained in a sanitary manner to prevent the harborage and feeding of ants.	F 372	F372 438.35(i)(3) **Dispose Garbage and Refuse Properly** The ants have been exterminated from the dumpster area. The area was cleaned and sprayed and the facility's pest control company was called to come to the facility to spray around the building again to eliminate pests. The garbage collection area is cleaned each morning after the dumpsters are emptied. The back dock area and dumpster is power washed weekly to prevent the harboring and feeding of ants or other vermin. Staff will be in-serviced to observe for ants and other pests in garbage areas daily when in this area. Maintenance personnel will be alerted when pest control is needed. The Dining services manager will make spot checks at least weekly to ensure staff are monitoring this area and are following procedure for maintaining this area in a sanitary manner.	08-09-10
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency	F 425	See page 11 for F 425	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445483	A. BUILDING _____ B. WING _____	07/29/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPALACHIAN CHRISTIAN VILLAGE	2012 SHERWOOD DRIVE JOHNSON CITY, TN 37601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 10 drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to obtain pharmaceutical services to ensure accurate receiving, dispensing, and labeling of medications for two non-facility residents of one medication room of two medications rooms reviewed. The findings included: Observation in the upstairs medication room on July 29, 2010, at 8:37 a.m., with the Assistant Director of Nursing (ADON) revealed two locked medication boxes with names of two non-facility residents on the boxes. Continued observation and interview with the ADON revealed the boxes contained medications brought to the facility by	F 425	**F 425 483.60(a),(b)** **Pharmaceutical Svc., Accurate Procedures, RPH** The facility's licensed nurses have ceased to prepare/pour medications from the prescription bottles into daily packs for these two Independent Living apartment residents. The licensed staff and personal care staff of the Independent Living apartments and the Independent Living Resident Director have been instructed that this former practice of medication prep is not permissible, using the facility staff. This practice will no longer be allowed. The Accounting Department has been notified that this medication prep will no longer be a service available using the staff of the facility. The billing code for this practice has been made 'inactive' so that this practice may not be used in the future. The Directors of Health Services and Independent Living will monitor all services contracted by Independent Living residents and any service requested by these residents from the facility licensed staff and will ensure proper procedure is followed in regards to adhering to policy. Medication prep/pouring into daily packs, by facility staff will not be allowed. 8/02/2010	08-02-10

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F 425	Continued From page 11 families of two residents residing in the Assisted Living facility next door (not the nursing home). Observation and interview revealed the charge nurses remove medications from the individual medication bottles and place them in into seperate container's representing the days of the week. Interview with the Administrator in the facility conference room on July 29, 2010, at 12:57 p.m., revealed the locked boxes belong to two individule residents residing in the Assisted Living facility and not to nursing home residents. Continued interview revealed that the facility charge nurses remove the medications from the original containers and place the medications into seperate containers representing the days of the week (daily planners) which are picked up by personal care attendants from the Assisted living facility next door. Further interview with the Administrator confirmed the charge nurses where dispensing and repackaging the medications.	F 425		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	**F 514 483.75(l)(1) Resident Records-Complete/Accurate/Accessible** This order which had been signed on the telephone order form, was re-faxed to the pharmacy with a request for the order to be printed on the Physician's Orders (recert) for the month of August, 2010. All Treatment Administration Records (TARs) and Physician Orders Sheets (recerts) were reviewed to ensure no treatments had been omitted by the pharmacy in the printing of the recerts for the month.	

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F 514	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to maintain an accurate clinical record for one resident (#7) of twenty-five residents reviewed. The findings included: Resident #7 was admitted to the facility on May 27, 2009, with diagnoses including Pressure Ulcer. Medical record review of a Physician's Telephone Order dated April 28, 2010, revealed, "...Calmoseptine Cr. (cream) to buttocks bid (twice daily) and PRN (as needed) due to irritation/redness..." Medical record review of the monthly Recapitulation Physician's Orders dated May 2010 through July 2010, revealed, no documentation of the Physician's Telephone Order daled April 28, 2010, for the Calmoseptine. Medical record review of the resident's Treatment Administration Record (TAR) dated April 2010 through July 2010, revealed the resident had been receiving the Calmoseptine as ordered on April 28, 2010. Interview with Treatment Nurses #1 and #2, at the Nurse's Station on July 28, 2010, at 10:10 a.m., confirmed the Physician's Telephone Order dated April 28, 2010, for Calmoseptine Cr. to buttocks bid and PRN due to irritation/redness, had not been transcribed to the Recapitulation Physician's Orders dated May 2010, through July 2010.	F 514	The treatment nurses will review TARs each month, comparing them to the recerts to ensure current orders appear on the recerts. If inconsistencies appear, the nurse will contact pharmacy for a corrected recert. The monthly review will be reported to the ADON. The ADON or DON will follow up with the pharmacy if corrections continue to be required, to determine where the communication can be improved to assure all orders are printed on the recerts monthly. Results of the reviews will be reported to the QA committee during their regularly scheduled meetings. 8/12/10	8/12/10

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F 514	Continued From page 13 Continued interview with Treatment Nurses #1 and #2 confirmed the facility failed to maintain an accurate clinical record for this resident.	F 514		